

Kevin's Review - 35 NCLEX Practice Questions

1. A male client with a nagging cough makes an appointment to see the physician after reading that this symptom is one of the seven warning signs of cancer. What is another warning sign of cancer?

- A. Rash
- B. Indigestion
- C. Chronic ache or pain
- D. Persistent nausea

Correct Answer: B. Indigestion

- **Option B:** Indigestion, or difficulty swallowing, is one of the seven warning signs of cancer. The other six are a change in bowel or bladder habits, a sore that does not heal, unusual bleeding or discharge, a thickening or lump in the breast or elsewhere, an obvious change in a wart or mole, and a nagging cough or hoarseness.
- **Options A and C:** Rash and chronic ache or pain seldom indicate cancer.
- **Option D:** Persistent nausea may signal stomach cancer but isn't one of the seven major warning signs.

2. The licensed practical nurse is assisting the charge nurse in planning care for a client with a detached retina. Which of the following nursing diagnoses should receive priority?

- A. Alteration in skin integrity
- B. Alteration in comfort
- C. Alteration in mobility
- D. Alteration in O2 perfusion

Correct Answer: C. Alteration in mobility

- **Option C:** Retinal detachment occurs when the retina becomes separated from the nerve tissue and blood supply underneath it. The client with a detached retina will have limitations in mobility since the vision is affected.
- **Options A and D:** These do not apply to the client with a detached retina.
- **Option B:** A detached retina produces no pain or discomfort.

3. The community nurse is following up on Mrs. Jenner who was hospitalized at Nurseslabs Medical Center due to depressive disorder, not otherwise specified, following the death of her spouse. In reviewing the client's chart, the nurse notes that Mrs. Jenner has an Axis II diagnosis of dependent personality disorder. Which behavior would the nurse anticipate in this client?

- A. Difficulty making decisions, lack of self-confidence.
- B. Grandiose thinking, attention-seeking behaviors.

- C. Odd mannerisms, speech, and behaviors.
- D. Unstable moods and impulsive behaviors.

Correct Answer: A. Difficulty making decisions, lack of self-confidence

The client with a dependent personality disorder typically demonstrates anxious and fearful behavior and is reluctant to make decisions. Lack of self-confidence is reflective of chronic low self-esteem. It involves fear of being alone and often causes those who have the disorder to do things to try to get other people to take care of them.

- **Option B:** Grandiose thinking and attention-seeking behaviors are characteristics of someone with a dramatic, emotional, erratic personality disorder, such as narcissistic personality. It is associated with self-centeredness, exaggerated self-image, and lack of empathy for others and is often driven by an underlying fragility in the sense of self.
- **Option C:** Odd mannerisms, speech, and behaviors are characteristics of schizotypal personality disorder, in which odd, eccentric behavior is displayed. Schizotypal personality disorder features odd speech, behavior, and appearance, as well as strange beliefs and difficulty forming relationships.
- **Option D:** Unstable moods and impulsive behaviors describe a borderline personality disorder. It is characterized by instability in interpersonal relationships, emotions, self-image, and impulsive behaviors.

4. Nurse Harry documents the presence of a scab on a client's deep wound. The nurse identifies this as which phase of wound healing?

- A. Inflammatory
- B. Migratory
- C. Proliferative
- D. Maturation

Correct Answer: B. Migratory

The scab formation is found in the migratory phase. It is accompanied by migration of epithelial cells, synthesis of scar tissue by fibroblasts, and development of new cells that grow across the wound. Wound healing is a natural physiological reaction to tissue injury. However, wound healing is not a simple phenomenon but involves a complex interplay between numerous cell types, cytokines, mediators, and the vascular system.

- **Option A:** In the inflammatory phase, a blood clot forms, epidermis thickens, and an inflammatory reaction occurs in the subcutaneous tissue. The inflammatory phase is characterized by hemostasis, chemotaxis, and increased vascular permeability which limits further damage, closes the wound, removes cellular debris and bacteria, and fosters cellular migration. The duration of the inflammatory stage usually lasts several days.
- **Option C:** During the proliferative phase, the actions of the migratory phase continue and intensify, and granulation tissue fills the wound. The proliferative phase is characterized by the formation of granulation tissue, reepithelialization, and neovascularization. This phase can last several weeks.
- **Option D:** In the maturation phase, cells and vessels return to normal and the scab sloughs off. The maturation and remodeling phase is where the wound achieves maximum strength as it matures.

5. A male client had a nephrectomy 2 days ago and is now complaining of abdominal pressure and nausea. The first nursing action should be to:

- A. Auscultate bowel sounds.
- B. Palpate the abdomen.
- C. Change the client's position.
- D. Insert a rectal tube.

Correct Answer: A. Auscultate bowel sounds.

If abdominal distention is accompanied by nausea, the nurse must first auscultate bowel sounds. If bowel sounds are absent, the nurse should suspect gastric or small intestine dilation and these findings must be reported to the physician.

- **Option B:** Palpation is the examination of the abdomen for crepitus of the abdominal wall, for any abdominal tenderness, or for abdominal masses. It may be used to assess the client but this will not be the first choice following a nephrectomy.
- **Option C:** Changing positions would not diminish the client's nausea and abdominal pressure.
- **Option D:** If peristalsis is absent, inserting a rectal tube won't relieve the client's discomfort.

6. A nurse has an African American patient who is bedridden for 3 months due to Guillain barre syndrome. During a routine assessment, which characteristic of pressure ulcer will the nurse first identify?

- A. Skin feels soft and cold
- B. Skin looks shiny or bluish in color
- C. Skin looks Reddish in color
- D. Skin returns to normal color after pressing it for 10 minutes

Correct Answer: B. Skin looks shiny or bluish in color

- Option B: People with darker skin will have patches of bluish to purplish a skin and will look shiny.
- Option A: Skin may feel hard and warm to touch instead.
- Option C: Usually Caucasian with bedsore will have patches of red skin.
- Option D: The skin color does not return to normal after pressing the area for 10-30 minutes.

7. The nurse can best ensure the safety of a demented client who wanders from the room by:

- A. Repeatedly reminding the client of time and place.
- B. Explaining the risks of becoming lost.
- C. Using soft restraints.
- D. Attaching a wander guard sensor band to the client's wrist.

Correct Answer: D. Attaching a wander guard sensor band to the client's wrist.

This type of identification band easily tracks the client's movements and ensures safety while wandering on the unit. Install bed alarms or pressure-sensitive doormats; this provides alarm to alert nurses of movement and help prevent injury to the patient. Avoid using restraints if at all possible. Restraints increase agitation, anxiety, and cause complications of immobility, feelings of powerlessness, and actual increased tendency for wandering.

- **Option A:** Assess patient for presence of wandering behavior, noting time, place, and people with whom he ambulates with. Helps to identify the gravity of the problem and to establish a plan of care. Purposeful wandering occurs when the patient has some intent for his movement, such as to escape boredom, or for exercises. Aimless wandering is usually purposeless and involves disoriented patients who may enter other patients' rooms and take their belongings. The escapist wandering usually has a destination in mind and is able to leave the premises undetected even though closely supervised.
- **Option B:** Instruct family regarding installing deadbolt locks, fences, locks on gates, and locks on doors and windows. Helps to prevent unsafe exits from home and for the protection of the patient. Instruct the family to notify neighbors and/or local police regarding the patient's condition and penchant for wandering. Provides awareness of others to prevent the patient from becoming lost or injured.
- **Option C:** Maintain a safe environment and structured routine for the patient. Allow the patient to wander within boundaries in a safe environment. Structure in the patient's routine may decrease wandering tendencies. Encourage the patient to participate in activities if able to do so. Exercise helps to decrease restlessness and may decrease potential wandering.

8. Which technique is considered the gold standard for diagnosing DVT?

- A. Ultrasound imaging
- B. Venography
- C. MRI
- D. Doppler flow study

Correct Answer: B. Venography

Proximal leg vein ultrasound, which when positive, indicates that the patient should be treated as having a DVT. If a patient scores 2 or above, either a proximal leg vein ultrasound scan should be done within 4 hours, and if the result is negative, a D-dimer test should be done. If imaging is not possible within 4 hours, a D-dimer test should be undertaken, and an interim 24-hour dose of a parenteral anticoagulant should be given. A proximal leg vein ultrasound scan should be carried out within 24 hours of being requested.

- **Option A:** Complex duplex ultrasound is the imaging modality of choice. There is non-compressible venous segment; loss of phasic flow on Valsalva maneuver; absent color flow if completely occlusive; lack of flow augmentation with calf squeeze; and increased flow in superficial veins.
- **Option C:** Vascular structures should always be interrogated during a routine assessment of the peripheries and pelvis. Incidental DVT has a prevalence of around 0.3% on routine outpatient knee MRI
- **Option D:** Doppler flow is a type of ultrasound. It uses sound waves to measure the flow of blood through a blood vessel. The results are shown on a computer screen in lines called waveforms. It's sometimes called Doppler velocimetry. A Doppler flow study may be used during pregnancy to check the health of the unborn baby (fetus).

9. A 79-year-old man with a known history of osteoporosis is admitted to the orthopedic ward after a fall in his garden, which led to a hip fracture. The interdisciplinary team convenes to discuss his immediate care plan. Recognizing the acute nature of his injury and the associated discomfort, the nurse contemplates which intervention should take precedence to ensure optimal patient comfort and recovery. Which of the following nursing actions should be given top priority for this patient?

- A. Promptly administering analgesic medications as prescribed by the physician.
 - B. Initiating gentle range of motion exercises for the affected limb.
 - C. Applying cold compresses to the fractured area to mitigate swelling.
 - D. Coordinating an early consultation with the physical therapy department.
- **Option B:** While range-of-motion exercises can be beneficial in the recovery phase, they are not the immediate priority following a fresh fracture. Starting them too early can exacerbate pain and potentially disrupt the healing process.
 - **Option C:** Applying ice packs may not be appropriate immediately after surgery or in the presence of open wounds.
 - **Option D:** Physical therapy is essential for rehabilitation after a fracture, but it's not the immediate priority. Initial focus should be on pain management and stabilization of the fracture.

10. You are caring for a patient with recurrent glioblastoma who is receiving dexamethasone (Decadron) 4 mg IV every 6 hours to relieve symptoms of right arm weakness and headache. Which assessment information concerns you the most?

- A. The patient does not recognize family members.
- B. The blood glucose level is 234 mg/dL.
- C. The patient complains of a continued headache.
- D. The daily weight has increased 1 kg.

Correct Answer: A. The patient does not recognize family members.

The inability to recognize a family member is a new neurologic deficit for this patient, and indicates a possible increase in intracranial pressure (ICP). This change should be communicated to the physician immediately so that treatment can be initiated.

- **Option B:** Increased blood glucose levels is an expected side effect but not an emergency.
- **Option C:** The continued headache also indicates that the ICP may be elevated, but it is not a new problem.
- **Option D:** The weight gain is a common adverse effect of dexamethasone that may require treatment, but is not an emergency.

11. The nurse is teaching a client with a history of obesity and hypertension regarding dietary requirements during pregnancy. Which statement indicates that the client needs further teaching?

- A. "I need to drink at least a quart of milk a day."
- B. "I need to reduce my daily intake to 1,200 calories a day."
- C. "I shouldn't add salt when I am cooking."
- D. "I need to eat more protein and fiber each day."

Correct Answer: B. "I need to reduce my daily intake to 1,200 calories a day."

- Option B: The client does not need to drastically reduce her caloric intake during pregnancy. Doing so would not provide adequate nourishment for the proper development of the fetus.
- Options A, C, and D: These statements indicate that the client understands the nurse's dietary teaching regarding obesity and hypertension; therefore, they are incorrect.

12. A 58-year-old male patient was diagnosed with pneumonia and was brought under your care. The patient complains of difficulty of breathing, chest pain of 5/10, and coughing with phlegm. Your initial assessment reveals a respiratory rate of 33 bpm, temperature of 38.1°C, heart rate of 90 bpm, and blood pressure of 110/80. His physician ordered an infusion of 1,000 mL of normal saline to be administered over the next eight (8) hours using a macroset with a drop factor of 10 drops per mL. You initiated the IV at 1:00 PM during your shift. With the current rate, at what time would you hang the next bag?

- A. 9:00 PM the next day.
 - B. 10:00 PM the next day
 - C. 9:00 PM of the same day.
 - D. 10:00 PM of the same day.
- C. 9:00 PM of the same day.
 - If the IV bag was started at 1:00 PM, add 8 hours more to get 9:00 PM of the same day.

13. Findings during an endoscopic exam include a cobblestone appearance of the colon in your patient. The findings are characteristic of which disorder?

- A. Ulcer
- B. Crohn's disease
- C. Chronic gastritis
- D. Ulcerative colitis

Correct Answer: B. Crohn's disease

Crohn's disease penetrates the mucosa of the colon through all layers and destroys the colon in patches, which creates a cobblestone appearance. As the inflammation progresses, non-caseating

granulomas form involving all layers of the intestinal wall. It can develop into the classic cobblestone mucosal appearances and skip lesions along the length of the intestine sparing areas with normal mucosa.

- **Option A:** In a gastric ulcer, on histopathology, one will see an ulcer base with clear margins that penetrate the muscularis propria and into the submucosa. Inflammatory debris on the epithelial surface is often present. In the submucosa, one will see fibrosis and thickened blood vessels.
- **Option C:** *H. pylori* infection's first appearance of gastritis tends to be antral. The inflammation, composing mainly of mononuclear inflammatory cells and plasma cells are superficial and mostly in the upper layers of the mucosa of the corpus (body of the stomach). The chronic inflammation of gastric mucosa is associated with neutrophilic inflammation; the effects are dependent on the cytotoxicity of the *H. pylori* strain.
- **Option D:** Histologically, the mucosal layer of the colon in a patient with ulcerative colitis includes infiltrates of varying density and composition, depending on the stage of the disease. These infiltrates primarily consist of lymphocytes, plasma cells, and granulocytes, with the latter being more prominent during acute flares of the disease.

14. A nurse caring for a patient receiving oxytocin therapy suddenly is experiencing hypertonic contractions. Which of the following priority nursing actions should the nurse do? Select all that apply.

- A. The nurse leaves the client to ask for help.
- B. Administer oxygen at 8 to 10 liters per minute.
- C. Stop the oxytocin infusion.
- D. Place the client in the supine position.
- E. Increase the flow rate of the intravenous additive solution.

Correct Answer: B, C, & E.

The presence of hypertonic contractions indicates the need to initiate emergency measures. The oxytocin infusion must be stopped to reduce uterine stimulation, administering oxygen will promote increased fetal and maternal oxygenation.

- **Option A:** The nurse should stay with the client.
- **Option D:** Placing the client in a supine position will not promote an increase in placental oxygenation.

15. Which component of the musculoskeletal system is responsible for the production of movement?

- A. Muscles
 - B. Ligaments
 - C. Bones
 - D. Tendons
- **Option B:** Ligaments connect bones to bones.

- **Option C:** Bones provide a framework and support.
- **Option D:** Tendons connect muscles to bones.

16. A patient is catheterized with a #16 indwelling urinary (Foley) catheter to determine if:

- A. Trauma has occurred.
- B. His 24-hour output is adequate.
- C. He has a urinary tract infection.
- D. Residual urine remains in the bladder after voiding.

Correct Answer: B. His 24-hour output is inadequate.

A 24-hour urine output of less than 500 ml in an adult is considered inadequate and may indicate kidney failure. This must be corrected while the patient is in the acute state so that appropriate fluids, electrolytes, and medications can be administered and excreted. Indwelling catheterization is not needed to diagnose trauma, urinary tract infection, or residual urine.

- **Option A:** Urinary bladder catheterization is performed for both therapeutic and diagnostic purposes. Based on the dwell time, the urinary catheter can be either intermittent (short-term) or indwelling (long-term).
- **Option C:** Cystitis, urethritis, prostatitis (common infectious etiology in men), and vulvovaginitis in the woman can cause urinary retention.
- **Option D:** Brain or spinal cord injury, cerebrovascular accident, multiple sclerosis, Parkinson's disease, and dementia can lead to urinary retention.

17. A pediatric nurse is performing a routine assessment of a one-month-old infant during a well-baby visit at the primary care clinic. The infant's mother reports no concerns and states that the baby has been feeding well and has had regular bowel movements. Upon assessment, which of the following findings warrants further investigation by the nurse? Select all that apply.

- A. Abdominal respirations
- B. Irregular breathing rate
- C. Inspiratory grunt
- D. Increased heart rate with crying
- E. Nasal flaring
- F. Cyanosis
- G. Asymmetric chest movement

Correct Answers: C, E, F, & G

- **Option C.** Grunting occurs when an infant attempts to maintain an adequate functional residual capacity in the face of poorly compliant lungs by partial glottic closure. As the infant prolongs the expiratory phase against this partially closed glottis, there is a prolonged and increased residual volume that maintains the airway opening and also an audible expiratory sound.

- **Option E:** Nasal flaring occurs when the nostrils widen while breathing and is a sign of troubled breathing or respiratory distress.
- **Option F:** Cyanosis refers to the bluish discoloration of the skin and indicates a decrease in oxygen attached to the red blood cells in the bloodstream.
- **Option G:** Asymmetric chest movement occurs when the abnormal side of the lungs expands less and lags behind the normal side. This indicates respiratory distress.
- **Option A:** Abdominal respiration is normal among infants and young children. Since their intercostal muscles are not yet fully developed, they use their abdominal muscles much more to pull the diaphragm down for breathing.
- **Option B:** Newborns can have irregular breathing patterns ranging from 30 to 60 breaths per minute with short periods of apnea (15 seconds).
- **Option D:** An increase in heart rate is normal for an infant during activity (including crying). Fluctuations in heart rate follow the changes in the newborn's behavioral state – crying, movement, or wakefulness corresponds to an increase in heart rate.

18. A 27-year old client, who became paraplegic after a swimming accident, is experiencing autonomic dysreflexia. Which condition is the most common cause of autonomic dysreflexia?

- A. Upper respiratory infection
- B. Incontinence
- C. Bladder distention
- D. Diarrhea

Correct Answer: C. Bladder distention

Autonomic dysreflexia is a potentially life-threatening complication of spinal cord injury, occurring from obstruction of the urinary system or bowel. In about 85% of cases, this stimulus is from a urological source such as a UTI, a distended bladder, or a clogged Foley catheter. The etiology is a spinal cord injury, usually above the T6 level. It is unlikely to occur if the level is below T10. The higher the injury level, the greater the severity of the cardiovascular dysfunction.

- **Option A:** An URI could obstruct the respiratory system, but not the urinary or bowel system. The severity and frequency of autonomic dysreflexia episodes are also associated with the completeness of the spinal cord injury. Patients usually develop autonomic dysreflexia one month to one year after their injury. However, it has also been described in the first days or weeks after the original trauma.
- **Option B:** The most common stimuli are distention of a hollow viscus, such as the bladder or rectum. Pressure ulcers or other injuries such as fractures and urinary tract infections are also common causes. Sexual intercourse can also be a stimulus.
- **Option D:** Incontinence and diarrhea don't result in obstruction of the urinary system or bowel, respectively. In an intact autonomic system, this increased blood pressure stimulates the carotid sinus leading to a parasympathetic outflow slowing the heart rate via vagal stimulation and causing diffuse vasodilation to balance the original increased sympathetic response. However, in the setting of a spinal cord injury, the normal compensatory parasympathetic response cannot travel below the level of the spinal cord injury, and generalized vasoconstriction continues below the level of injury leading to systemic hypertension.

19. You're teaching Anthony how to use his new colostomy. How much skin should remain exposed between the stoma and the ring of the appliance?

1/16"

1/4"

1/2"

1"

Correct Answer: A. 1/16"

Only a small amount of skin should be exposed and more than 1/16" of skin allows the excrement to irritate the skin. It is expected that the stoma will change its size (get smaller) for the first four to six weeks after surgery due to the swelling that occurs post-op.

- **Option B:** Cut the wafer slightly larger to accommodate the expansion. Doing this also helps to prevent the wafer from "strangulating" the stoma by putting too much pressure around it.
- **Option C:** Make sure that there's about a 1/16 – 1/8" (approx. 1.5 – 3mm) gap between the stoma and the edge of the hole. Remember, as wafers do swell, the patient may need to adjust this gap accordingly. If using a barrier ring or similar product, it is okay to cut the hole slightly larger
- **Option D:** The pouching system must be completely sealed to prevent leaking of the effluent and to protect the surrounding peristomal skin. The disposable pouching systems can be either a one-piece or a two-piece flexible system consisting of a plastic bag and a flange (skin barrier) that sit against the patient's skin. The flange may be flat or convex.

20. The nurse is aware that the outcome criteria would be appropriate for a child diagnosed with oppositional defiant disorder?

- A. Accept responsibility for own behaviors.
- B. Be able to verbalize own needs and assert rights.
- C. Set firm and consistent limits with the client.
- D. Allow the child to establish his own limits and boundaries.

Correct Answer: A. Accept responsibility for own behaviors

Children with oppositional defiant disorder frequently violate the rights of others. They are defiant, disobedient, and blame others for their actions. Accountability for their actions would demonstrate progress for the oppositional child. Oppositional defiant disorder (ODD) is a type of childhood disruptive behavior disorder that primarily involves problems with the self-control of emotions and behaviors. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the main feature of ODD is a persistent pattern of angry or irritable mood, argumentative or defiant behavior, or vindictiveness toward others.

- **Option B:** This is incorrect as the oppositional child usually, focuses on his own needs. Temperamental factors such as irritability, impulsivity, poor frustration, tolerance, and high levels of emotional reactivity are commonly associated with ODD. While not all children diagnosed with ODD show callous and unemotional traits, it has been shown that such traits are highly heritable and may be seen more frequently in a subset of children with more significant disruptive behaviors.
- **Option C:** Treatment of oppositional defiant disorder is multimodal and should involve the patient, family, school, and community. Identifying and treating comorbidities (like ADHD, depression, and

anxiety) and modifiable risk factors (such as bullying and learning difficulties) should be done. Treatment may also vary based on whether oppositional behavior primarily occurs in specific contexts or if the behavior is pervasive and thus requires more intensive treatment.

- **Option D:** This is not an outcome criterion but an intervention. Parent Management Training or PMT is based on the principles of social learning theory and is the main treatment for oppositional behaviors. The guiding principle in PMT is the use of operant conditioning (using the role of positive reinforcement in changing behaviors) to decrease unwanted behaviors and promote prosocial behaviors. Methods include teaching parents to identify problem behaviors as well as positive interactions and to apply punishment or reinforcement as appropriate.

21. Successful ethical discussion depends on people who have a clear sense of personal values. When many people share the same values it may be possible to identify a philosophy of utilitarianism, with proposes that:

- A. The value of people is determined solely by leaders in the Unitarian church.
- B. The decision to perform a liver transplant depends on a measure of the moral life that the client has led so far.
- C. The best way to determine the solution to an ethical dilemma is to refer the case to the attending physician.
- D. The value of something is determined by its usefulness to society.

Correct Answer: D. The value of something is determined by its usefulness to society.

A utilitarian system of ethics proposes that the value of something is determined by its usefulness. Utilitarianism is a theory of morality, which advocates actions that foster happiness or pleasure and opposes actions that cause unhappiness or harm. When directed toward making social, economic, or political decisions, a utilitarian philosophy would aim for the betterment of society as a whole.

- **Option A:** Utilitarianism is a theory of morality, which advocates actions that foster happiness and opposes actions that cause unhappiness. Utilitarianism promotes “the greatest amount of good for the greatest number of people.”
- **Option B:** As patient advocates, it’s our duty to ensure that our patients receive all of the necessary information, such as potential risks, benefits, and complications, to make well-informed decisions. The healthcare team can then formulate care in compliance with the patient’s wishes. Family members should refrain from making decisions for the patient or inflicting undue pressure to alter his or her decisions unless the patient is incapacitated or found to be legally incompetent.
- **Option C:** Paternalism provides the power for healthcare professionals to make decisions to reveal or conceal a diagnosis, potential treatment modalities, or expected prognosis. An example of paternalism is when we admit an adolescent with multiple complete cervical spine fractures whose family is stating that the teen needs to participate in a state basketball championship in 3 months. The benefit of sharing the anticipated prognosis of quadriplegia at this time is far outweighed by the potential emotional trauma it may cause the family.

22. Mr. and Ms. Byers’ child failed to pass meconium within the first 24 hours after birth; this may indicate which of the following?

- A. Celiac disease
- B. Intussusception

- C. Hirschsprung's disease
- D. Abdominal-wall defect

Correct Answer: C. Hirschsprung's disease

Failure to pass meconium within the first 24 hours after birth may be a sign of Hirschsprung's disease, a congenital anomaly resulting in mechanical obstruction due to weak motility in an intestinal segment. History of the colonic obstruction, which might occur during the early neonatal period till adulthood, along with failure to pass meconium during the first 48 hours of the life, which presents in up to 90% of the affected patients, is highly compatible with the impression of HD.

- **Option A:** Celiac disease, also known as gluten-sensitive enteropathy, is an autoimmune disease of the small intestine. Celiac disease is a condition in which the body responds to gluten with an inappropriate immune response causing small intestinal inflammation and damage.
- **Option B:** Intussusception is a condition in which part of the intestine folds into the section next to it. Intussusception usually involves the small bowel and rarely the large bowel. Symptoms include abdominal pain which may wax and wane, vomiting, bloating, and bloody stool.
- **Option D:** Failure to pass meconium is not connected with abdominal wall defect. Gastroschisis is a paraumbilical abdominal wall defect associated with protrusion of the bowel through the defect. A membrane does not cover the bowel exposed in utero and, as a result, may be matted, dilated, and covered with a fibrinous inflammatory rind.

23. Steve is diagnosed with celiac disease and experiences celiac crisis secondary to upper respiratory tract infection; which of the following would Nurse Nancy expect to assess?

- A. Lethargy
- B. Weight gain
- C. Respiratory distress
- D. Watery diarrhea

Correct Answer: D. Watery diarrhea

Episodes of celiac crises are precipitated by infections, ingestion of gluten, prolonged fasting, or exposure to anticholinergics. Celiac crisis is typically characterized by severe watery diarrhea. Celiac crisis is a life-threatening syndrome in which patients with celiac disease have profuse diarrhea and severe metabolic disturbances.

- **Option A:** Irritability, rather than lethargy, is more likely. Clinically it is characterized by severe diarrhea, dehydration, and metabolic disturbances including hypokalemia, hyponatremia, hypocalcemia, hypomagnesemia, and hypoproteinemia.
- **Option B:** Because of the fluid loss associated with severe watery diarrhea, the child's weight is more likely to be decreased. In childhood, failure to thrive is an important aspect of history, while in adulthood the corresponding symptom would be unexplained weight loss.
- **Option C:** Respiratory distress is unlikely in a routine upper respiratory tract infection. Symptoms from other than gastrointestinal systems include recurrent aphthous ulcers in the mouth, iron deficiency anemia, ataxia, chronic headaches, and delayed menarche.

24. Nurse Gina is aware that the dietary implications for a client in manic phase of bipolar disorder is:

- A. Serve the client a bowl of soup, buttered French bread, and apple slices.
- B. Increase calories, decrease fat and decrease protein.
- C. Give the client pieces of cut-up steak, carrots, and an apple.
- D. Increase calories, carbohydrates, and protein.

Correct Answer: D. Increase calories, carbohydrates, and protein.

This client increased protein for tissue building and increased calories to replace what is burned up (usually via carbohydrates). Eating a balance of protective, nutrient-dense foods. These foods include fresh fruits, vegetables, legumes, whole grains, lean meats, cold-water fish, eggs, low-fat dairy, soy products, and nuts and seeds. These foods provide the levels of nutrients necessary to maintain good health and prevent disease, in general.

- **Option A:** In addition to lowering caffeine, it's important to avoid high-fat meals with some bipolar medications. High-fat meals may delay the time it takes for some bipolar medications to be absorbed into your system.
- **Option B:** Watching caloric intake and exercising regularly to maintain a healthy weight. Some findings show that those with bipolar disorder may have a greater risk for being overweight or obese.
- **Option C:** Decreasing environmental stimulation may assist the client to relax; the nurse must provide a quiet environment without noise, television, and other distractions; finger foods or things the client can eat while moving around are the best options to improve nutrition.

25. A client in labor is transported to the delivery room and is prepared for cesarean delivery. The client is transferred to the delivery room table, and the nurse places the client in the:

- A. Trendelenburg's position with the legs in stirrups.
- B. Semi-Fowler position with a pillow under the knees.
- C. Prone position with the legs separated and elevated.
- D. Supine position with a wedge under the right hip.

Correct Answer: D. Supine position with a wedge under the right hip.

Vena cava and descending aorta compression by the pregnant uterus impedes blood return from the lower trunk and extremities. This leads to decreasing cardiac return, cardiac output, and blood flow to the uterus and the fetus. The best position to prevent this would be side-lying with the uterus displaced off of abdominal vessels. Positioning for abdominal surgery necessitates a supine position; however, a wedge placed under the right hip provides displacement of the uterus.

- **Option A:** Use of Trendelenburg position during prolonged active labor does not decrease the incidence of cesarean delivery and may be associated with poor fetal outcomes. Prospective, randomized data on the topic of maternal positioning in labor would further elucidate the role, if any, for Trendelenburg position in labor.
- **Option B:** When maternal position in left lateral tilt was compared with the horizontal position, there was no influence on the incidence of hypotension, and there were no changes in systolic and

diastolic blood pressure.

- **Option C:** Prone position is inappropriate during cesarean delivery. When the full left lateral tilt was compared with left lateral tilt, maternal position did not increase the risk of hypotension and there were no changes in systolic and diastolic blood pressure.

26. A miotic medication has been given to a patient with glaucoma. The nurse tells the client that the purpose of this medication is to?

- A. It blocks the responses that are sent to the eye muscles.
- B. It will relax the eye muscles and decrease blurring of vision.
- C. It will constrict the eye to reduce intraocular pressure.
- D. It will dilate the eye to reduce intraocular pressure.

Correct Answer: C. It will constrict the eye to reduce intraocular pressure.

Miotics cause pupillary constrictions and are used to treat glaucoma. These medications reduce eye pressure by increasing the drainage of intraocular fluid through the trabecular meshwork.

- **Options A, B, & D:** These are related to mydriatic medications.

27. Which of the following danger signs should be reported promptly during the antepartum period?

- A. Constipation
- B. Breast tenderness
- C. Nasal stuffiness
- D. Leaking amniotic fluid

Correct Answer: D. Leaking amniotic fluid

Danger signs that require prompt reporting leaking of amniotic fluid, vaginal bleeding, blurred vision, rapid weight gain, and elevated blood pressure.

- **Option A:** Postpartum constipation, with symptoms such as pain or discomfort, straining, and hard stool, is a common condition affecting mothers. Hemorrhoids, pain at the episiotomy site, effects of pregnancy hormones, and haematinics used in pregnancy can increase the risk of postpartum constipation. Eating a high-fiber diet and increasing fluid intake is usually encouraged, although laxatives are commonly used in relieving constipation.
- **Option B:** The breasts may be extra tender as early as one or two weeks after conception. This is because the body is making so much estrogen and progesterone in early pregnancy that the glands in the breasts start growing. This hormone surge causes breasts to retain more fluids and feel heavy, sore, or more sensitive than normal PMS tenderness.
- **Option C:** Pregnancy rhinitis is an inflammation of the mucous membranes lining the nose. This causes nasal congestion. Increased blood flow to the nasal passages and enlargement of the nasal veins also play a role.

28. As a knowledgeable nurse, you know that you should never give amphetamines in combination with:

- A. Oral hypoglycemics
- B. Insulin
- C. MAO inhibitors
- D. Antihypertensives

Correct Answer: C. MAO inhibitors

MAO inhibitors must never be given with drugs affecting the CNS because hypertension can occur. Amphetamine is contraindicated during or within 14 days of MAOI therapy, e.g., phenelzine, due to the risk of hypertensive crisis.

- **Option A:** Amphetamines can be given with oral hypoglycemics and insulin as long as blood sugar levels are monitored because these can decrease antidiabetic requirements.
- **Option B:** Amphetamines mediate their behavioral effects by stimulating dopaminergic signaling throughout reward circuits of the brain. This property of amphetamine relies on its actions at the dopamine transporter (DAT), a presynaptic plasma membrane protein responsible for the reuptake of extracellular dopamine. Recently, researchers have revealed the novel ability of insulin signaling pathways in the brain to regulate DAT function as well as the cellular and behavioral actions of amphetamine.
- **Option D:** Amphetamine enhances recovery after experimental ischemia and has shown promise in small clinical trials when combined with motor or sensory stimulation. Amphetamine, a sympathomimetic, might have hemodynamic effects in stroke patients, although limited data have been published.

29. During a hearing assessment, the nurse notes that the sound lateralizes to the clients left ear with the Weber test. The nurse analyzes this result as:

- A. A normal finding.
- B. A conductive hearing loss in the right ear.
- C. A sensorineural or conductive loss.
- D. The presence of nystagmus.

Correct Answer: C. A sensorineural or conductive loss.

In the Weber tuning fork test the nurse places the vibrating tuning fork in the middle of the client's head, at the midline of the forehead, or above the upper lip over the teeth. Normally, the sound is heard equally in both ears by bone conduction. If the client has a sensorineural hearing loss in one ear, the sound is heard in the other ear. The inner ear is more sensitive to sound via air conduction than bone conduction (in other words, air conduction is better than bone conduction).

- **Option A:** Weber test does not demonstrate lateralization: in a normal subject, the sound should be heard in the middle and equally on both sides. In the primary care setting, it is useful to use the Weber test along with the Rinne test to help the clinician differentiate between conductive hearing loss and sensorineural hearing loss. This will guide the clinician to the need for further examination, investigation, and management.

- **Option B:** If the client has a conductive hearing loss in one ear, the sound is heard in that ear. In the presence of a purely unilateral conductive hearing loss, there is a relative improvement in the ability to hear a bone-conducted sound. In the presence of sensorineural hearing loss, the sound will be perceived louder in the unaffected ear, which has the better cochlear.
- **Option D:** Nystagmus is a rhythmic, involuntary, rapid, oscillatory movement of the eyes. The Weber test is a useful, quick, and simple screening test for evaluating hearing loss. The test can detect unilateral conductive and sensorineural hearing loss. The outer and middle ear mediate conductive hearing. The inner ear mediates sensorineural hearing.

30. Which statement by a patient with an ileostomy alerts the nurse to the need for further education?

- A. "I don't expect to have much of a problem with fecal odor."
- B. "I will have to take special precaution to protect my skin around the stoma."
- C. "I'm going to have to irrigate my stoma so I have a bowel movement every morning."
- D. "I should avoid gas forming foods like beans to limit funny noises from the stoma."

Correct Answer: C. "I'm going to have to irrigate my stoma so I have a bowel movement every morning"

This statement is inaccurate in relation to an ileostomy and indicates that the patient needs more teaching. An ileostomy produces liquid fecal drainage that is constant and cannot be regulated. An ileostomy is when the lumen of the ileum (small bowel) is brought through the abdominal wall via a surgical opening (created by an operation). This can either be temporary or permanent, an end or a loop. The purpose of an ileostomy is to evacuate stool from the body via the ileum rather than the usual route of the anus.

- **Option A:** The odor from drainage is minimal because fewer bacteria are present in the ileum compared with the large intestine. There are different indications for forming an ileostomy but essentially arrive at the same result of diverting stool out of the body without it ever entering the colon.
- **Option B:** An ileostomy is an opening into the ileum (distal small intestine from the jejunum to the cecum). Cleansing the skin, skin barriers, and a well fitted appliance are precautions to protect the skin around the ileostomy stoma. The drainage from ileostomy contains enzymes that can damage the skin.
- **Option D:** An ileostomy stoma does not have a sphincter that can control the flow of flatus or drainage, resulting in noise. The output from an ileostomy consists of loose or porridge-like stool consistent with that expected to pass through the small bowel (as it is the large bowel that is responsible for making the stool more solid dependent upon water absorption). The output from an ileostomy can vary but typically ranges from 200 to 700 ml per day, and an ileostomy is typically formed on the right side of the abdomen.

31. Chuck is a 20-year-old student diagnosed with obsessive-compulsive behavior. A psychiatrist prescribes clomipramine (Anafranil) to treat his condition. Nurse Nicolette understands the rationale for this treatment is that the clomipramine:

- A. Increases dopamine levels

- B. Increases serotonin levels
- C. Decreases norepinephrine levels
- D. Decreases GABA levels

Correct Answer: B. Increases serotonin levels

According to the psychobiological theory, dysregulation of the neurotransmitter serotonin is thought to contribute to obsessive-compulsive behavior. Clomipramine (Anafranil) is used to increase serotonin levels, thereby decreasing the need for obsessive-compulsive behaviors. The only FDA-approved use for clomipramine is for the treatment of the obsessive-compulsive disorder (OCD) in ages 10 and older. Clomipramine was the first FDA-approved medication for OCD in 1989. For the treatment of OCD, a meta-analysis found clomipramine was more effective than sertraline, fluoxetine, and fluvoxamine.

- **Option A:** Clomipramine is a tertiary amine belonging to the class of medications known as tricyclic antidepressants (TCA). It is a dibenzazepine TCA. Clomipramine is a serotonin reuptake inhibitor (S-RI) with a stronger affinity for the serotonin transporter (SERT), compared to other TCAs and S-RIs. The resulting action of clomipramine increases serotonergic and noradrenergic transmission.
- **Option C:** Metabolism of clomipramine is primarily through the liver via oxidation by CYP450 2D6. The half-life of clomipramine is 17 to 28 hours. Clomipramine is then metabolized to the steady-state active metabolite desmethyl clomipramine by CYP450 1A2. Desmethyl clomipramine has more noradrenergic activity than serotonergic.
- **Option D:** Experts often use fluvoxamine, a CYP450 1A2 inhibitor, with clomipramine in treatment-resistant OCD. By adding the CYP450 1A2 inhibitor, the conversion from clomipramine to desmethyl clomipramine is blocked, resulting in increased serotonergic activity. The onset of action of clomipramine is usually between 6 to 12 weeks for OCD; it may treat anxiety or insomnia immediately. If the patient achieves OCD remission with clomipramine, treatment should continue indefinitely.

32. The primary complication of a central venous access device (CVAD) is:

- A. Thrombus formation in the vein.
- B. Pain and discomfort.
- C. Infection.
- D. Occlusion of the catheter as the result of an intra-lumen clot.

Correct Answer: C. Infection.

A foreign body in a blood vessel increases the risk of infection. Catheters that come outside the body have an even higher risk of infection. Most infections are caused by skin bacteria. Other infective organisms include yeasts and fungi. Infection is a serious delayed complication associated with central venous access that can lead to sepsis, shock, and death. Central line-associated bloodstream infections have a reported incidence between 80–189 episodes per 100,000 patient years, and the Centers for Disease Control and Prevention (CDC) estimates the additional cost per infection to be on average approximately \$16,550.[45] Mortality related to central line infection can occur in up to 25% of cases. Infections become established on the catheter through the production of biofilm. Staphylococcus aureus and Staphylococcus epidermidis are the two most common pathogens.

- **Option A:** Long-term catheters can also lead to venous thrombosis. Symptoms include ipsilateral extremity erythema, edema, and paresthesia. Additionally, thrombosis can lead to superior vena

cava syndrome, which can present as head and neck swelling. The incidence of superior vena cava syndrome is estimated to be 1 in 1,000 cases. Subclavian central venous catheters have the lowest rate of thrombosis. Femoral lines have the highest rate of thrombosis. Cancer patients have a higher risk of central line thrombosis of up to 41%. Primary thromboprophylaxis has no proven benefit in the oncologic or cancer-free population.

- **Option B:** Once placed, these lines do not cause pain and discomfort. A central line is necessary when the client needs drugs given through the veins over a long period of time, or when the client needs kidney dialysis. In these cases, a central line is easier and less painful than having needles put in the veins each time the client needs therapy.
- **Option D:** An occlusion can result from the precipitation of calcium phosphate crystals when calcium and phosphorus are co-administered at inappropriate concentrations. If the pH of an infusion is too alkaline or acidic, precipitation can occur. Parenteral nutrition preparations can leave a lipid residue that can obstruct a CVC.

33. Nurse Bea notices a female client sitting alone in the corner smiling and talking to herself. Realizing that the client is hallucinating. Nurse Bea should:

- A. Invite the client to help decorate the dayroom.
- B. Leave the client alone until he stops talking.
- C. Ask the client why he is smiling and talking.
- D. Tell the client it is not good for him to talk to himself.

Correct Answer: B. Leave the client alone until he stops talking

This provides a stimulus that competes with and reduces hallucination. Decrease environmental stimuli when possible (low noise, minimal activity). Decrease the potential for anxiety that might trigger hallucinations. Helps calm the client. Be alert for signs of increasing fear, anxiety or agitation. Might herald hallucinatory activity, which can be very frightening to client, and client might act upon command hallucinations (harm self or others).

- **Option A:** Explore how the hallucinations are experienced by the client. Exploring the hallucinations and sharing the experience can help give the person a sense of power that he or she might be able to manage the hallucinatory voices. Help the client to identify the needs that might underlie the hallucination. What other ways can these needs be met? Hallucinations might reflect needs for anger, power, self-esteem, and sexuality.
- **Option C:** Keep to simple, basic, reality-based topics of conversation. Help the client focus on one idea at a time. Client's thinking might be confused and disorganized; this intervention helps the client focus and comprehend reality-based issues. Work with the client to find which activities help reduce anxiety and distract the client from hallucinatory material. Practice new skills with the client. If clients' stress triggers hallucinatory activity, they might be more motivated to find ways to remove themselves from a stressful environment or try distraction techniques.
- **Option D:** Accept the fact that the voices are real to the client, but explain that you do not hear the voices. Refer to the voices as "your voices" or "voices that you hear". Validating that your reality does not include voices can help the client cast "doubt" on the validity of their voices. Engage the client in reality-based activities such as card playing, writing, drawing, doing simple arts and crafts or listening to music. Redirecting the client's energies to acceptable activities can decrease the possibility of acting on hallucinations and help distract from voices.

34. The nurse is planning to teach a client with COPD how to cough effectively. Which of the following instructions should be included?

- A. Take a deep abdominal breath, bend forward, and cough 3 to 4 times on exhalation.
- B. Lie flat on back, splint the thorax, take two deep breaths and cough.
- C. Take several rapid, shallow breaths and then cough forcefully.
- D. Assume a side-lying position, extend the arm over the head, and alternate deep breathing with coughing.

Correct Answer: A. Take a deep abdominal breath, bend forward, and cough 3 to 4 times on exhalation.

The goal of effective coughing is to conserve energy, facilitate the removal of secretions, and minimize airway collapse. The client should assume a sitting position with feet on the floor if possible. The client should bend forward slightly and, using pursed-lip breathing, exhale. After resuming an upright position, the client should use abdominal breathing to slowly and deeply inhale. After repeating this process 3 or 4 times, the client should take a deep abdominal breath, bend forward and cough 3 or 4 times upon exhalation ("huff" cough).

- **Option B:** Lying flat does not enhance lung expansion; sitting upright promotes full expansion of the thorax. Sit on a chair or on the edge of the bed, with both feet on the floor. Lean slightly forward. Relax. The patient should breathe in through their nose and out through their nose or mouth until they are ready to progress to the next stage.
- **Option C:** Shallow breathing does not facilitate removal of secretions, and forceful coughing promotes collapse of airways. The client should lean forward, press the arms against the abdomen. Cough 2-3 times through a slightly open mouth. Coughs should be short and sharp. The first cough loosens the mucus and moves it through the airways. The second and third cough enables the client to cough the mucus up and out.
- **Option D:** A side-lying position does not allow for adequate chest expansion to promote deep breathing. Sitting the patient out of bed or up in bed optimizes lung expansion. Critical care patients can sit out of bed if they are hemodynamically stable (this allows for better lung expansion). Ensure you have two to three clinicians assisting with any intravenous lines, cardiac monitoring, drain tubes, etc.

35. After falling 20', a 36-year-old man sustains a C6 fracture with spinal cord transaction. Which other findings should the nurse expect?

- A. Quadriplegia with gross arm movement and diaphragmatic breathing.
- B. Quadriplegia and loss of respiratory function.
- C. Paraplegia with intercostal muscle loss.
- D. Loss of bowel and bladder control.

Correct Answer: A. Quadriplegia with gross arm movement and diaphragmatic breathing

A client with a spinal cord injury at levels C5 to C6 has quadriplegia with gross arm movement and diaphragmatic breathing. Cervical spine injuries, although uncommon, can result in significant and long-term disability. The cervical spine encompasses seven vertebrae and serves as a protection to the spinal cord. C5 to C7 are responsible for deep tendon reflexes of the biceps, brachioradialis, and triceps respectively. C5 controls shoulder abduction with the aid of C4 and elbow flexion with the aid of

C6. C6 to C7 are responsible for elbow extension, wrist extension, and flexion.

- **Option B:** Injury levels C1 to C4 leads to quadriplegia with total loss of respiratory function. C1 to C3 are responsible for movements of the head, the dermatome of C2 is responsible for sensation to the dorsal aspect of the head, and C3 is responsible for sensation to the lateral aspects of the face and posterior portion of the head. C3 to C4 contribute to breathing by controlling the muscles of the diaphragm.
- **Option C:** Paraplegia with intercostal muscle loss occurs with injuries at T1 to L2. This term refers to impairment or loss of motor and/or sensory function in the thoracic, lumbar or sacral (but not cervical) segments of the spinal cord, secondary to damage of neural elements within the spinal canal. With paraplegia, arm functioning is spared but the trunk, legs and pelvic organs may be involved depending on the level of injury.
- **Option D:** Injuries below L2 cause paraplegia and loss of bowel and bladder control. A spinal cord injury may interrupt communication between the nerves in the spinal cord that control bladder and bowel function and the brain, causing incontinence. This results in bladder or bowel dysfunction that is termed “neurogenic bladder” or “neurogenic bowel.”